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[Extract from the COUNTRY PRACTITIONER for April, 1880.]

SOME REMARKS ON

TUBERCULOUS LARYNGITIS,

As Viewed Laryngoscopically.

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There are several groups of manifestations of tuberculous degeneration of the tissues of the larynx, independent of individual complications, which can hardly fail to strike those who have frequent opportunities for inspecting these lesions in consumptives.

I. The most frequent, according to my own experience, is a pyriform swelling of the tissues about the supra-arytenoid cartilages, due chiefly, as determined under the microscope, to accumulation of lymphatic cells in the connective tissue. The outline of the posterior portion of the fold of tissue extending from the epiglottis to the supra-arytenoid cartilage of each side —for this form of the manifestation is most frequently bilateral though not symmetric—is rounded instead of being sharply defined, and tapers off more or less towards the epiglottic portion of the structure. The swelling prevents due approximation of the internal faces of the arytenoid cartilages, consequently due approximation of the posterior portions of the vocal bands which are attached to these cartilages, and thus engenders an impairment of voice, amounting to entire absence if the swelling is considerable, even though the vocal bands are in every way normal. This swelling rarely subsides. The local manifestation may be limited to the condition described, or it may be associated, progressively or simultaneously, with other local lesions, immediately adjacent or at a distance.

II. The next most frequent manifestation in my own experience, and one not infrequently associated with the pyriform induration first described, though often enough unassociated with any evidence of it, is a tumefaction of the connective tissue in the fold of structure uniting the two arytenoid cartilages. The inner or laryngeal face of this inter-arytenoid fold or commissure, is raised into irregular longitudinal or spindle-shaped ridges; sometimes indeed, infiltrated to such a degree as to form submucous neoplasms, which intervene as wedges between the opposing surfaces of the arytenoid cartilages, and thus produce a mechanical impediment to the production of

sound; and the voice may be dysphonic or aphonic as in the instances already alluded to, and, like them, without any impairment of the integrity of the vocal bands themselves.

This form of the affection is exceedingly apt to terminate in erosion of the mucous membrane, frequently extending to ulceration through it—a fact not surprising when it is borne in mind that this inter-arytenoid fold is constantly being folded up, as it were, in phonation, so that the ridges rub each other until their mutual attrition eventuates in solution of tissue. There is a partial folding and unfolding too, in quiet respiration; and thus it is easily understood why the impossibility of normal complete rest to the part prevents repair in the majority of instances; and why the repair which occasionally follows absolute rest to the part, abnormally secured by artificial respiration through a tracheal orifice, gives false hopes of ultimate recovery from the disease, to palliate the incessant cough and dyspnœa of which the operation of tracheotomy may have been performed.

III. The vocal bands are the seat of the next most frequent lesion, as I have seen it. They become infiltrated, thickened into veritable vocal cords, often rugous on their superior surface, and are as red in color, usually, as the general lining mucous membrane. In many instances they remain of a dingy white aspect, occasionally redder or paler according to circumstances. This condition of the vocal bands may be independent of any other appreciable local lesion in the larynx, but it is frequently associated with one of the conditions previously mentioned or with both of them. When existing alone, there is no mechanical impediment to the approximation of the arytenoid cartilages and of the posterior portions of the vocal bands, and hence the voice is not interfered with; but the tone of the voice is altered, with a gruff husky quality due to alteration in the tension and flexibility of the vocal bands, and consequent irregular vibrations. When associated with lesions of the supra-arytenoid or of the intra-arytenoid structures, there may be aphonia independently of the lesion in the phonal bands themselves.

IV. The epiglottis is a frequent seat of lesion in the cases under consideration, often, at least at first and for a long time, without association with any other local lesion, and when so associated, most frequently with a certain amount of the pyriform infiltration of the aryteno-epiglottic fold first described. The epiglottis becomes thickened to double, triple, quadruple its normal dimensions, pale, curled together on the sides so as to resemble the shape of a crescent, a horse-shoe, or even a turban. With this is associated infiltration of the epiglotto-pharyngeal folds, sometimes to such a degree as to complicate recognition of the structures. The result is that due occlusion of the larynx does not take place in deglutition and dysphagia results—food readily falling into the unoccluded air passage. There is, in consequence, more absolute distress experienced in this variety of the lesion than in any other, while the interference with due nourishment exhausts the patient more rapidly,

so that, not infrequently, he succumbs in from six to eighteen months from the presumable onset of the lesion, while he may subsist for four, five or more years with either of the lesions previously described.

The epiglottis, too, in occasional cases, undergoes a partial constriction, so that one side or the other presents as an irregular globose swelling, not infrequently mistaken for a morbid growth of the part, and sometimes actually subjected to an unnecessary and futile amputation.

In some cases again, the epiglottis undergoes progressive destruction, usually from the side, in cases in which it is infiltrated, and from the lower portion of its internal face, upward, in cases in which it has not undergone this peculiar infiltration, or has undergone thickening to but a moderate extent. The opinion prevalent among the profession that ulcerative destruction of the epiglottis in this manner is a manifestation peculiar to syphilis is an erroneous one, to which the chances of recovery or amelioration of an unfortunate consumptive is sometimes undoubtedly sacrificed. Syphilis may be a much more frequent systemic destroyer of the epiglottis, but is by no means the only one.

V. Another distinct lesion of phthisical destruction of the tissues of the larynx, is an erosion of the mucous membrane over the vocal processes of the arytenoid cartilages. It may be unilateral or bilateral. It may be evanescent or amenable to remedies, or it may be permanent and unamenable to remedies. In either instance it may exist independent of any other appreciable local lesion whatever; in which case the voice remains practically unimpaired for the time, and may even be used in public. This use is detrimental to the patient; but as the voice is good, and the only symptom is an annoying titillation, exciting occasional cough, the victim is unaware of the existence of any serious lesion, and cannot realize the gravity of his condition when it is explained to him.

Any and all of the lesions described may become associated together; any and all of them may progress to ulceration which may extend in various directions, comprising the entire structure of the larynx, superficially or in depth. Any and all of them occasionally persist for years without progression or retrogression. Any and all of them occasionally subside under treatment and without it. All of them are associated with pulmonary phthisis, although its physical manifestations are at times so slight as to elude detection, or so indefinite as to give the patient the benefit of the doubt.

I have failed by the most persistent questioning, to associate any one form of the lesion more than another with hereditary predisposition to consumption, with any other family predisposition, with hemoptysis or with special calling or vocation.